BOARD OF COUNTY COMMISSIONERS

AGENDA ITEM SUMMARY

Meeting Date: September 20, 2006 Division: Employee Services

Bulk Item: Yes X No Department: Employee Benefits Office

Staff Contact Person: Maria Z. Fernandez-Gonzalez

AGENDA ITEM WORDING: Approval of the amended Employee Health Plan Document to become effective January 1, 2007.

ITEM BACKGROUND: Last plan document revision was October 1, 1996 and approved by the BOCC in February 1997.

PREVIOUS RELEVANT BOCC ACTION: N/A

CONTRACT/AGREEMENT CHANGES: N/A

STAFF RECOMMENDATIONS: Approval

TOTAL COST: N/A **BUDGETED:** Yes **X** No

COST TO COUNTY: N/A **SOURCE OF FUNDS: Primarily Ad Valorem**

REVENUE PRODUCING: Yes No **X** **AMOUNT PER MONTH** **Year**

APPROVED BY: County Atty X OMB/Purchasing X Risk Management X

DOCUMENTATION: Included **X** To Follow Not Required

DISPOSITION: **AGENDA ITEM #**

Revised 08/06

COUNTY of MONROE
KEY WEST FLORIDA 33040
(305) 294-4641

Office of the Employee Services Division Director
The Historic Gato Cigar Factory
1100 Simonton Street, Suite 268
Key West, FL 33040
(305) 292-4458 – Phone
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TO: Board of County Commissioners

FROM: Teresa Aguiar, Director
Employee Services

DATE: August 31, 2006

SUBJ: Plan Document Revision

This item requests approval of the amended Employee Health Plan Document to become effective January 1, 2007. The Plan is the sole document used in determining the benefits of eligible Covered Persons under the Health Insurance Plan. It was originally effective on October 1, 1996 and was last approved by the BOCC in February of 1997. Gallagher Benefit Services, Inc. worked with us in revising this document.

The major revisions are mentioned below:

- Section 1: Diabetes supply coverage will no longer be covered under Medical and is now covered under the Prescription Plan. This change benefits the employee since the employee will no longer be subject to the deductible. There is no significant cost impact to the County for this change.
- Section 6: Currently, covered individuals who are employed by a covered entity, must meet the family deductible in addition to one of them meeting their individual deductible (total of $900). The proposed change will benefit the employee and allow the deductibles be cumulative (totaling $600).
- Section 6: Addition of Hospice benefit and coverage of nursing care from an Advanced Registered Nurse Practitioner (ARNP). These benefits are not covered under the current Plan, however, they were consistently waived due to it benefiting the employee and being more cost effective for the County.
- Section 7: This is a new benefit for the employee which is in the proposed budget for Fiscal Year 06/07. Costs will be absorbed from the current fund. There will not be any cost for the employee. This benefit provides a maximum payable of $400 per year per covered individual and is not subject to a deductible or co-payment percentage. This benefit will enable covered individuals to take increased responsibility for their health behaviors and ultimately reduce health care costs.
- Section 12: Updated language regarding COBRA which also eliminates the need to provide separate COBRA notices to new employees and newly acquired dependents.

These revisions are minor updates and/or changes. They do not affect how benefits are currently applied:

- Section 1: Updated language on networks and prescription plan.
- Section 2: Addition of the Retiree Resolution and Domestic Partner eligibility.
- Section 3: Addition of language regarding open enrollment and special enrollment, creditable coverage and effective date of coverage.
- Section 5: Clarified language regarding Cost Containment Procedures.
- Section 8, 9, 10, 11: Language clarified and updated.
- Section 13: Addition of language regarding Qualified Medical Child Support Order procedures.
- Section 14: New section – HIPAA.
- Section 15: Language clarified and updated.
- Section 16: Definitions – Updated

If you have any questions, please do not hesitate to contact me at X4458.

EMPLOYEE HEALTH PLAN

Board of County Commissioners
Clerk of the Circuit Court
Property Appraiser
Tax Collector
Supervisor of Elections
Sheriff's Department

of Monroe County

Effective January 1, 2007

Section 817.234 of the Florida Statutes stipulates that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

The Board of County Commissioners/Monroe County (BOCC) has established an Employee Health Plan (the "Plan") to maintain medical and prescription benefits for its employees and their eligible dependents who are beneficiaries of the Plan.

This Plan, originally effective on October 1, 1996, is amended and restated effective January 1, 2007.

The purpose of this document is to set forth the provisions of the Plan that provide for the payment or reimbursement for all or a portion of covered medical and prescription expenses.

Benefits of the Plan shall be payable for expenses incurred on or after the effective date of the Plan document, in accordance with the terms of the Plan in effect on the date the expense was incurred, except as otherwise specified.

This Plan document supersedes all other prior Plan documents and amendments and shall be the sole document used in determining benefits for which Covered Persons are eligible. The Plan document may be amended from time to time by the BOCC, in its sole discretion, to reflect changes in benefits or eligibility requirements, or changes in the law. It is not in lieu of and does not affect any requirements for coverage by Workers' Compensation. It is the responsibility of each Covered Person to understand their benefits, rights and obligations under the Plan.

The Plan Administrator has the discretionary authority to make decisions regarding eligibility for benefits under the Plan and to construe and interpret the provisions of the Plan.

Please refer to the Definitions Section (Section 16) of the Plan for an explanation of certain terms used in the Plan document.

Wherever used in the Plan document, masculine pronouns shall include both masculine and feminine genders and the singular shall include the plural unless the context indicates otherwise.

Table of Contents

Section 1 – Schedule of Benefits

Medical

Maximums

Major Medical Benefits	$1,000,000 Lifetime

Deductibles

Calendar Year Deductible – per individual	$300**
Family Maximum	$600
Hospital – per period of Confinement	$150
Emergency Room – per visit	$75

Note: If Emergency Room visit results in admission to the hospital, the Emergency Room Deductible will be waived.

Co-Payment Percentage

Covered Expenses 75% of the first $30,000
100% thereafter per individual per calendar year

Note: Full benefits are subject to compliance with the Keys Physician Hospital Alliance (KPHA) Preadmission Certification/Length of Stay Approval programs. Failure to obtain required Preadmission Certification or Length of Stay Approval will result in a **30%** reduction in benefits for all covered services related to that claim. **KPHA can be reached at (305) 294-4599 or (800) 400-0984 for questions or to initiate compliance.**

Benefit for all Outpatient Treatment by a Physician of a Mental/Nervous Disorder	50% of charges
Benefit for all Outpatient Treatment of Chemical Dependency (alcoholism or drug abuse)	50% of charges, subject to $25,000 lifetime maximum*
Benefit for Inpatient or Partial Hospitalization Treatment of a Mental/Nervous Disorder	30 days per calendar year

Preferred Provider Organization Networks

The Plan currently offers three Preferred Provider Organization Networks (PPO). The advantages of utilizing a PPO Provider is that the Plan saves money through pre-negotiated discounts and the Participant saves money through discounts on their share of expenses (co-pays). In addition, the Participant will not be responsible for charges in excess of Usual, Customary and Reasonable Charges because of Provider pre-negotiated fees.

The Plan utilizes the following Preferred Provider Organization (PPO) networks:

- Keys Physician-Hospital Alliance – 305-294-4599 or 1-800-400-0984 (Monroe County)
- Dimension Network – 1-800-483-4992 or www.dimensionhealth.com (Dade, Broward & Palm Beach Counties)
- Multiplan Network – 1-800-557-6794 or www.multiplan.com (Nationwide)

Out of Network Penalty: Failure to utilize a Provider from one of our PPO Networks (for non-emergencies) will result in a 30% penalty on all related charges.

1. If a Participant uses a network facility for Inpatient/outpatient Surgery, but the network facility uses a non-network Provider for Anesthesia, the interpretation of laboratory tests and x-rays, and other Medically Necessary services, the Plan will consider benefits In-Network and the Out-of-Network Penalty will not apply.
2. If certain covered Providers, such as ambulance services, Home Health Care Agencies, Hospice Care Agencies or specialized surgeons, provide Covered Services to a Participant that are not available through one of the PPO networks, those Covered Services will be considered In-Network and the Out-of-Network Penalty will not apply.
3. If network Providers are not accessible on a temporary basis (e.g. students, on vacation or out of country), the Plan will consider benefits for the Providers as In-Network and the Out-of-Network Penalty will not apply.

* This plan will allow only one confinement per an individual's lifetime for treatment of a chemical dependency.

**This deductible will be waived in situations where the Participant's Spouse or Domestic Partner, who is also an employee of an Employer, has elected family coverage under the Plan.

Section 1 – Schedule of Benefits

Prescription Coverage

The Prescription Drug Program became effective October 1, 1996. You can obtain your prescriptions either at a participating retail pharmacy by presenting your ID card and paying the co-pay at the time of service, by using the mail service program or *Advantage 90*. Complete details are contained in the Prescription Drug Program Booklet. If you have not received a Prescription Drug Program Booklet, you may request one from the Employee Benefits Office.

Co-payments. The amount of money that you must pay for each prescription is:

	Retail	Mail Service/*Advantage90*™*
Generic	$10.00	$25.00
Brand	$25.00	$62.50
Non-Preferred Brand	$70.00	$175.00

Please note that if a generic substitute is available and permissible by law but you choose to receive the brand drug instead, you will be responsible for both the generic co-pay plus the difference between the brand and generic price of each drug.

Maximum Days Supply

Retail	Mail Service
30 days	90 days

Covered Drugs

1. Drugs which require a prescription (except those listed in the non-covered list)
2. Compound prescriptions containing at least one legend ingredient
3. Diabetes supplies (including insulin and other pharmaceutical supplies)

**Advantage90*™ is offered through Walgreens Health Initiatives (WHI). *Advantage90*™ allows you to get 90-day supplies of your maintenance medications at select retail outlets, including: Albertsons, CVS, Kmart, Publix and Walgreens.

To start receiving your 90-day prescriptions from either a retail outlet or through the mail, simply obtain a new prescription written for a 90-day supply from your doctor. And, to make the most of your savings on prescriptions, please share with your physician the WHI Formulary Guide, which will assist your doctor in prescribing the most affordable and effective treatment for you.

For a copy of WHI's formulary or to get answers to your questions about *Advantage90*™, please visit www.mywhi.com or contact WHI Member Services department 24 hours a day, seven days a week, at 1 (800) 207-2568.

Section 2 – Eligibility

You and your Eligible Dependents can be eligible to receive benefits under the Plan after you complete 60 days of continuous service.

Active Employees. To be eligible as an active employee, you must be an active full-time employee, who is directly employed in the regular business of and compensated for services by the Employer and regularly works 25 or more hours a week.

Retirees. To be eligible as a retiree, you must be a retiree who fits within one of the following categories, and you must pay the following cost:

If you fall under one of the following:	You pay:
Current Retiree	Cost equal to HIS* for 10 years
Normal retirement under §121.021 (29) F.S., from Monroe County & FRS with 10 years full-time service	Cost equal to HIS* for 10 years
Early retirement under §121.021 (30), from Monroe County & FRS with 10 years full-time service AND EITHER age 60, or age and years of service added together total 70	Cost equal to HIS* for 10 years
Early retirement under §121.021 (30), from Monroe County & FRS with 10 years full-time service, NOT age 60, and age and years of service do not add up to 70	Pay Departmental Rate until you reach age 60 or satisfy Rule of 70**
Retire from FRS without 10 years full-time service with Monroe County	Pay Departmental Rate
Employees hired on/after 10/01/01 who retire from Monroe County & FRS with 10 years full-time service	Pay Departmental Rate
Re-enrollment under Monroe County group health program upon retirement with 10 years full-time service and Monroe County was last FRS employer	Pay Departmental Rate
*HIS stands for "health insurance subsidy" **Rule of 70: You satisfy the Rule of 70 if your age, combined with the number of years of service you have with Monroe County, totals 70 or more. Note: The 10 years of service requirement is 8 years for elected officials.	

Eligible Dependents. To be eligible as an Eligible Dependent, the individual must be:

1. Your Spouse;
2. Your Surviving Spouse
3. Your Domestic Partner*; or
4. Your Child

which terms are defined below.

"Spouse" means a person of the opposite sex to whom you are legally married under federal law (and from whom you are not legally separated).

"Surviving Spouse" means a person of the opposite sex to whom you were legally married under federal law (and from whom you were not legally separated) at the time of your death as a retired Participant.

"Domestic Partner" means a person over the age of 18 who has chosen to share his or her life with you in a committed family relationship of mutual caring as long as you and that individual:

1. consider yourselves to be members of one another's immediate family;
2. agree to be jointly responsible for one another's basic living expenses;
3. are not otherwise married or a member of another domestic partnership;
4. are not blood related in a way that would prevent you from being married to one another under the laws of Florida;
5. are each of at least legal age and competency required by Florida law to enter into a marriage or other binding contract;
6. reside at the same residence; and
7. each sign a Declaration of Domestic Partnership available from the Employee Benefits Office. An updated Declaration of Domestic Partnership may be required periodically, but not more frequently than annually. The Employee Benefits Office may also ask for substantiation of the Declaration.

   *Note: If you enroll a Domestic Partner in the Plan, the cost of those benefits to your Employer will be considered taxable wages to you. You might consider discussing the tax implications of enrolling a Domestic Partner in the Plan with your tax advisor prior to enrolling your Domestic Partner.

"Child" means a child (1) who bears one of the following Required relationships to you AND (2) who meets the following Child eligibility requirements:

1. Required Relationship:

   a. Your natural born child, or
   b. Your legally adopted child (beginning the moment s/he is placed in your custody for adoption). However, with respect to an adopted newborn, when the child is placed in your residence, s/he will be considered a Child under the Plan from the moment of birth, provided a written agreement to adopt such child has been entered into by you prior to birth
   c. Any child, who resides in your household in a regular parent-child relationship, if s/he qualifies as your exemption under the Internal Revenue Code; or
   d. A foster child who resides in your household in a regular parent-child relationship, if s/he qualifies as your exemption under the Internal Revenue Code; or

e. A newborn child, up to the age of 18 months, of your covered unmarried dependent Child.

2. Child eligibility requirements:

   a. The Child is unmarried and has not attained the age of 19; or
   b. The unmarried Child is a student under the age of 24 (student defined as enrolled in an accredited school on a full or part-time basis earning at least 6 credits per semester); or
   c. The unmarried Child is at least 24, but under 25, is a student (defined above), and earns less than $3,200 per year; or
   d. The unmarried Child already covered under the Plan and who is beyond the ages specified above if on the date of attainment s/he is incapable of self-sustaining employment because of mental retardation or physical handicap and is principally dependent on you for support and maintenance*. Proof of such incapacity must be provided to the Employer within 31 days of the Child's birthday, and from time to time thereafter upon the Employer's request. In addition, the Employer may request that the Child submit to examinations from time to time.
   e. **In all cases, the Child must reside with you for more than ½ the year, must provide less than ½ his or her own support, and be named as a dependent on your most recent federal income tax return.**

If both parents are covered under this Plan for Personal Benefits, then either parent, but not both, may cover a child for Dependent Benefits. No individual can be covered for both Personal and Dependent Benefits.

It is your responsibility to notify the Plan if your Child experiences a status change that would affect his or her eligibility under the Plan.

*Proof may be required.

Exceptions: If your Eligible Dependent is employed and covered under a group plan or plans sponsored by their employer, the day immediately following the date such coverage terminates due to the termination of your Eligible Dependent's employment may also be deemed to be the date you acquired that Eligible Dependent and any other Eligible Dependent who had been covered under that plan. Written proof of loss of coverage must be submitted to the Employee Benefits Office within 31 days of the loss of coverage or else the Eligible Dependent cannot be added until the next Open Enrollment period.

Section 3 – When Coverage Begins

Initial Enrollment.

For You. If you are eligible, you must complete the required enrollment forms, and coverage will be effective after sixty (60) days of continuous service from your date of hire or the date your properly completed enrollment forms are received by the Employee Benefits Office, whichever is later.

If you are not Actively at Work on the date coverage begins, your coverage will become effective on the date you return to Active Work.

For your Eligible Dependents. If you wish the Plan to provide coverage for your Eligible Dependents, you must enroll and authorize contributions for Dependent Benefits. Coverage for your Eligible Dependents will begin as follows:

1. If you enroll your Eligible Dependents (Spouse, Domestic Partner and/or Child) at the time you enroll, coverage for those Eligible Dependents will begin on the date your coverage begins. Otherwise, you will have to wait until Open Enrollment to enroll your Eligible Dependents.
2. If you are not married or have no children at the time you become covered, you will become eligible for Dependent Benefits on the date you acquire your first Eligible Dependent(s) through marriage, birth, adoption, or otherwise as stated under "Eligibility". Coverage for each of those Eligible Dependents will begin on the date eligible, provided you have enrolled and authorized contributions for Dependent Benefits on or before that date.
3. If you delay enrollment but still enroll within 30 days of the date eligible, coverage will be effective on the date you enroll, unless the Eligible Dependent is acquired through birth or adoption (or placement for adoption), in which case coverage will be retroactive to the date of birth or adoption (or placement for adoption). Contributions for delayed enrollment must be paid retroactively to the effective date. If you fail to enroll a newly acquired dependent within 30 days of acquisition, you must wait to enroll the dependent until the next Open Enrollment Period. This will apply even though you have other Eligible Dependents who are not enrolled for coverage under the Plan.

If one of your Eligible Dependents, other than a newborn, is confined in a hospital or in an Extended Care Facility on the date coverage would normally begin, s/he cannot receive benefit coverage until the day following discharge from that confinement.

After your coverage becomes effective, please notify the Employee Benefits Office promptly of new dependents or dependents who are no longer eligible due to a change in their status because of marriage, divorce, separation, age (of children), student, or mental or physical handicap qualifications.

For those Eligible Dependents not previously enrolled, the "Open Enrollment" provision will apply.

Open Enrollment. During the Plan's Open Enrollment Period, you may elect Plan coverage for your Eligible Dependents, or modify or eliminate coverage under the Plan for your Eligible Dependents. Any changes elected during the Plan's Open Enrollment Period shall be effective as of the first day of the Plan Year immediately following the close of the Open Enrollment Period. If you or your Eligible Dependent had not previously participated in the Plan and you elect new coverage during the Open Enrollment Period, you shall be subject to the Plan's Pre-Existing Condition limitations and all other terms and provisions of the Plan. If you make a modification to existing coverage during Open Enrollment, you shall not be subject to a new Pre-Existing Condition limitation.

Special Enrollment Rights. If you are declining enrollment for your Eligible Dependents (including your Spouse) because of other health insurance coverage or group health plan coverage, you may be able to enroll your Eligible Dependents in the Plan if they lose eligibility for that other coverage or if the Employer stops contributing towards your Eligible Dependent's coverage. However, you must request enrollment within 30 days after the other coverage ends or after the Employer stops contributing towards the other coverage.

In addition, if you have a new Eligible Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll your Eligible Dependent(s). However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

To request a Special Enrollment or to obtain more information, please contact the Employee Benefits Office.

Pre-Existing Condition Limitation. Expenses incurred for treatment of a Pre-Existing Condition shall be excluded from coverage under the Plan and not considered Covered Medical Expenses if medical advice, diagnosis, care or treatment was recommended or received with respect to such Pre-Existing Condition within the six (6) month period ending on the Employee's date of hire or the Dependent's effective date of coverage under the Plan; provided, however, that such exclusion shall extend for a period of not more than twelve (12) months (or eighteen (18) months in the case of a Late Enrollee) after the Employee's date of hire and the period of such Pre-Existing Condition exclusion shall be reduced by the aggregate of the periods of Creditable Coverage applicable to the Employee as of his date of hire and the Dependent's effective date of coverage.

Rules Relating to Crediting Previous Coverage.

1. Breaks in Coverage. A period of Creditable Coverage shall not be counted with respect to enrollment under the Plan, if, after such period and before the enrollment date, there was a sixty-three (63) day period during all of which the individual had no Creditable Coverage. Periods of Creditable Coverage shall be established through presentation of certifications or in such other manner as may be specified in regulations under ERISA.
2. Method of Crediting Service Standard Method. The Plan shall count a period of Creditable Coverage without regard to the specific benefits covered during the period.
3. Certifications and Disclosure of Coverage. The Plan shall provide a certification at the following times:
    a. At the time a Participant ceases to be covered under the Plan or otherwise becomes covered under a COBRA Continuation Provision;
    b. In the case of a Participant becoming covered under a COBRA Continuation Provision, at the time the Participant ceases to be covered under such provision; and
    c. Upon the request of an individual made not later than twenty-four (24) months after the date of cessation of the coverage.
        (1) The certification shall be a written certification of the period of Creditable Coverage of the individual under the Plan and the coverage, if any, under the COBRA Continuation Provision and, if applicable, the Waiting Period imposed with respect to the individual for coverage under the Plan.

Exceptions to Pre-Existing Condition Exclusion.

1. Certain Newborns. The Pre-Existing Condition exclusion described above shall not apply in the case of an individual who, as of the last day of the **thirty (30)** day period beginning with the date of birth has Creditable Coverage; provided, however, this exception shall no longer apply to an individual after the end of the first sixty-three (63) day period during all of which the individual did not have any Creditable Coverage.
2. Certain Adopted Children. The Pre-Existing Condition exclusion described above shall not apply in the case of a Child who is adopted or Placed for Adoption before attaining 18 years of age and who, as of the last day of the **thirty (30)** day period beginning on the date of the adoption or placement for adoption, has Creditable Coverage; provided, however, the prior sentence shall not apply to coverage before the date of such adoption or Placement for Adoption and, provided further, this exception shall no longer apply to an individual after the end of the first sixty-three (63) day period during all of which the individual did not have any Creditable Coverage.
3. Pregnancy. The Pre-Existing Condition exclusion described above shall not apply to any Pre-Existing Condition relating to Pregnancy.

Section 4 – When Coverage Terminates

When Will Coverage Under the Plan Terminate?

For you and your Eligible Dependents. Coverage for you and your Eligible Dependents will terminate on the earliest of the following dates:

1. On the date your employment terminates; or
2. On the date the Plan is discontinued; or
3. On the date you or your Eligible Dependents are no longer eligible for coverage under the Plan; or
4. On the date you begin active duty in the Armed Forces for longer than two weeks, unless you are on an approved leave of absence, discussed further below; or
5. On the date ending the period for which contributions (if required) have been paid, if you cease making contributions.

Cessation of Active Work. If you cease Active Work, your coverage and that of your Eligible Dependent(s) will terminate. However, if you cease Active Work because of Injury, Sickness, pregnancy, medical leave of absence, or temporary layoff, your Employer in its sole discretion may continue your coverage for a limited time, provided you make any required contributions. Please note the following:

1. If you are absent from work because of an approved medical leave of absence, your coverage may be considered to continue, until terminated by the Employer, but for no longer than 6 months from the date the leave started, provided you make required contributions. The same rules will apply to you if you leave active employment for military service.
2. The Employer must signify an employee's termination of employment by notifying the Employee Benefits Office.
3. If subsequent to termination of service and coverage, you (except if you are a Participant returning from active military duty for longer than two weeks) are reemployed or reinstated as an eligible Participant, you will be treated in the same manner as a new Participant at the date of such reemployment or reinstatement. However, there will be a grace period of 2 working days following the date of termination of service during which you may be rehired or reinstated without penalty. Benefits will not be payable for expenses incurred during that 2 day period unless you are rehired or reinstated.
4. If subsequent to termination of service and coverage, you return from active military duty of two weeks or longer and are reemployed or reinstated as an eligible Participant, you will be treated as if you were on an approved leave of absence for purposes of eligibility for coverage. The preexisting condition limitation, eligibility waiting periods and evidence of insurability provisions of the Plan will not apply to your reinstatement into the Plan.

In addition, coverage for each Eligible Dependent also terminates on the earliest of the following dates:

1. On the date s/he ceases to be an Eligible Dependent due to such things as:
    a. For a Spouse, divorce from you,
    b. For a Child, attainment of the allowed age, loss of "dependent status" or losing status as a "student" as defined in the Plan; or
2. On the date s/he becomes covered for Personal Benefits under the Plan; or
3. On the date s/he begins active duty in the Armed Forces for longer than two weeks; or
4. On the date that you request that coverage for that Eligible Dependent be terminated.

In the event of a retiree's death, the surviving spouse and eligible dependents may continue on the Plan provided the individual was a covered dependent under this Plan at the time of the retiree's death and makes any required contributions on a timely basis. Coverage for a surviving spouse and eligible dependent is subject to the eligibility requirements of this Plan.

A surviving spouse who remarries is no longer eligible to continue coverage under this Plan.

Coverage for Mentally Retarded and/or Physically Handicapped Children. Dependent Benefits for a Mentally Retarded and/or Physically Handicapped Child may not be continued beyond the earliest of the following:

1. Cessation of the physical handicap; or
2. Failure to furnish any required proof of mental retardation and/or physical handicap or to submit to any required examination within a reasonable time period; or
3. Termination of Dependent Coverage for the Child for any reason other than attaining the limiting age.

The Plan Administrator (or its designee) will have the right to require due proof of the continuation of the mental retardation and/or physical handicap and will have the right and opportunity to have the Child examined whenever it may reasonably require during its continuation. After 2 years have elapsed from the date the Child attained the limiting age, only one examination may be required annually.

Contact the Employee Benefits Office for further clarification.

Section 5 – Cost Containment Procedures

Mandatory Preadmission Certification/Length of Stay Approval. If you or your Eligible Dependent(s) requires **non-emergency** hospital confinement for:

1. A covered Injury;
2. Sickness;
3. Mental/Nervous Disorder at a Mental Disorder Treatment Facility; or
4. Inpatient treatment at a Substance Abuse Treatment Facility,

then Preadmission Certification and Length of Stay Approval must be obtained from the Plan utilization review and case management firm, currently Keys Physician Hospital Alliance, (KPHA), prior to admission. **In the event of an emergency admission, certification must be obtained within 48 hours from the date of admission.**

Full benefits for hospital charges will be paid only for approved admissions and confinement days.

If confinement extends beyond the approved Length of Stay, additional days must be preauthorized by KPHA. Full benefits for hospital charges will be paid only for the approved number of extended confinement days. **All covered charges incurred during that hospitalization will be reduced by 30% for those extended confinement days not approved.**

> ***NOTE: Failure to obtain required Preadmission Certification or Length of Stay Approval will result in a 30% reduction in benefits for all covered services related to that claim. NO benefits will be paid for non-emergency admissions from 12:01 a.m. on Friday to 12:01 a.m. on Monday, unless otherwise authorized by KPHA.**

Requirements for Pre-Certification.

1. Non-Emergency Admissions. If you or your Eligible Dependent requires a hospital confinement of overnight or longer, hospital Preadmission Certification and Length of Stay Approval must be completed prior to being ***scheduled*** *or at least five (5) business days prior to a non-emergency surgical or medical admission or procedure.*
2. Emergency Admissions. In the event of an emergency admission, certification must be obtained from the KPHA within 48 hours from the date of admission. *Observation Admissions (also know as 23 hour stays)* are considered "emergency" or "urgent" admission. (Example: Admitted from the emergency room, directly from your doctor's office or following outpatient surgery). Certification must be obtained from the KPHA within 48 hours from the date of the admission.

3. Obstetrical Admissions. Preadmission Certification is not required for any hospital length of stay in connection with childbirth for the mother or newborn child if less than or equal or equal to forty-eight (48) hours following a normal vaginal delivery or less than or equal to ninety-six (96) hours following a cesarean section. **Hospital lengths of stay exceeding these time periods require Preadmission Certification.**
4. Pre-Certification Program for Diagnostic Procedures and Services. A pre-procedure review must be done for specified elective, non-emergency outpatient diagnostic procedures. This review consists of screening using predetermined criteria for determination of medical necessity. This should be completed prior to the procedure being *scheduled or at least five (5) business days prior to the non-emergency surgical or medical procedure.*

   If the clinical information submitted does not meet the established guidelines/criteria to justify the procedure, the case will be reviewed by a physician reviewer for a determination.

   The following is a list of outpatient diagnostic procedures and services that require pre-certification:

Radiology	Other
CT and CTA Brain	Durable Medical Equipment (DME)
MRI Brain, Lumbar and Cervical	(excludes diabetic testing monitors & supplies; surgical dressings)
MRA Brain and Carotids	Home Health Services

5. Pre-Certification Program for Diagnostic Procedures and Services. **All surgeries that require or request an admission of an overnight stay.** Pre-Surgical Review must be done for specified elective, non-emergency surgeries. This review consists of screening using predetermined criteria and determination of medical necessity. This should be completed prior to the procedure being *scheduled or at least five (5) business days prior to the non-emergency surgical or medical procedure.*

   If the clinical information submitted does not meet the established guidelines/criteria to justify the procedure, the case will be reviewed by a Physician Reviewer for determination.

   There is no *mandatory* second surgical opinion program. However, one may be recommended after physician review.

   If your physician or Physician Reviewer has recommended a second opinion, it must be obtained from a Board Certified surgeon in that specific specialty. If a second opinion was recommended and the surgery is performed without the necessary pre-surgical review and/or if the second opinion (if needed) was not obtained by a board-certified surgeon prior to surgery, all covered charges which are related to that surgery will by reduced by **30%.**

If a second opinion is non-confirming, a third opinion may be recommended in order to receive full benefits. It is not necessary that the third opinion be confirming.

Medical Case Management. The Case Management Services serves the individual and the special needs of patients and their families due to illness or injury. Case Managers act as liaison between the patient, physician, therapist, home health agency, third party administrator and employer coordinating all services in order that each individual client return to their optimal potential. Under the program, each of the following may constitute a catastrophic sickness or injury:

- Major Head Trauma
  And Brain Injury Secondary to Illness
- Amyotrophic Lateral Sclerosis (ALS)
- Neonatal High Risk Infant
- Spinal Cord Injuries
- Multiple Fractures
- Multiple Sclerosis (MS)
- Any Claim expected to exceed $60,000.00
- Severe Burns
- Amputations
- Transplants
- Leukemia
- Cancer
- AIDS
- Home Health needs
- Durable Medical Equipment needs

When the KPHA is notified of one of the above diagnoses or needs (or any other diagnosis for which Medical Case Management might be appropriate) by the covered person or family, his physician, or the employer, the KPHA Case Manager will consult with the attending physician to develop a plan of treatment which will include all services and supplies to be utilized, as well as the most appropriate treatment setting. The treatment plan may be modified as the covered person's condition or needs change.

All services and supplies authorized by the Case Manager will be considered covered expenses, whether or not they are otherwise covered under the plan. The benefit level for institutions will be the same as the hospital benefit level would be in the absence of the large Case Management program. For all services and supplies, the benefit level will be the same as the benefit for outpatient medical treatment would be in the absence of the program.

Any deviation from the treatment plan without KPHA's prior approval may negate the treatment plan and all charges will be subject to the regular provisions of this Plan.

Section 6 – Medical Provisions

If you or your Eligible Dependent are covered and require treatment, services, or supplies because of Injury or Sickness, the benefits described will be payable.

How Payments are Made. Unless otherwise stated in the Schedule of Benefits, and after the deductible is satisfied, payment will be made as follows:

- 75% of the first $30,000 of Covered Medical Expenses, then 100% of expenses for covered services incurred during a Calendar Year by you or your Eligible Dependent subject to applicable limitations for mental and nervous and/or chemical dependency.

- Thus, the Out-of-Pocket amount you have to pay in a Calendar Year per person is $7,800 (25% of $30,000 plus the $300 deductible), plus any incurred inpatient deductibles and any other non-covered expenses.

Out-of-Pocket means the sum of any covered expenses applied toward the Calendar Year deductible plus your 25% share of the co-payment. However, the Out-of-Pocket Limit does not include any expenses you must pay for outpatient treatment of mental and nervous disorders and chemical dependency.

Maximum Benefits. The Maximum Benefit stated in the Schedule of Benefits is the maximum amount payable during a person's lifetime. All benefits payable are subject to that amount. Reimbursement will continue for each covered individual for successive Sicknesses or Injuries up to the Maximum Benefit in the Schedule of Benefits.

Deductible. The amount of the deductible to be paid by you is specified in the Schedule of Benefits. It applies separately to you and each of your Eligible Dependents each calendar year.

If 2 or more members of your family are injured in the same Accident, only one deductible will be applied in the Calendar Year in which the Accident occurred against all the combined expenses incurred as a result of such accident. You are responsible for advising the Claims Administrator of such an occurrence subject to Review Procedures.

After members of your family have cumulatively satisfied the family maximum deductible in a Calendar Year, no further deductible will be applied in that year against expenses incurred by members of your family.

Where you and your Spouse or Domestic Partner are both employed by an Employer, and one of you has elected family coverage, only the family deductible must be met for the calendar year for the Family Unit.

Extended Benefits. If coverage for you or your Eligible Dependent terminates, and you are totally disabled on the date of termination, the benefits provided in this section of the Plan shall continue to be payable solely for the Injury or Sickness which caused the total disability during such period of continuous and total disability, just as if coverage had not terminated, and subject to all provisions of the Plan, but not for longer than 12 months after the date of termination.

With respect to the above, such benefits shall cease on the date you or your dependent becomes covered under any other group plan.

Covered Medical Expenses. The following Medical Expenses are covered under the Plan:

Inpatient Hospital Expenses:**

1. Room and Board Charges;
2. Operating, delivery and treatment rooms and equipment;
3. Intensive care, cardiac care or other similar necessary accommodations;
4. Ancillary Charges.

****The Plan may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section, or require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of said periods. Hospital lengths of stay exceeding these times periods require Precertification.**

Extended Care Facility Charges. Extended Care Facility Charges will be paid if all of the following are met:

1. The Participant must first be confined in a Hospital for at least three (3) days or the stay must be determined to be Medically Necessary rather than for Custodial Care;
2. A Physician recommends confinement for convalescence from the condition or related condition which caused the Hospital confinement;
3. The Participant is under the continuous care of a Physician during the entire period of confinement; and
4. The Participant commences his stay in the Extended Care Facility within forty-eight (48) hours following discharge from the Hospital – (Maximum confinement of thirty-one (31) days). Eligible Extended Care Facility charges shall be Room and Board Charges and Ancillary Charges, not including any charges for professional services ordered by a Physician and furnished by the facility for Inpatient care.

Outpatient Hospital Expenses.

1. Diagnostic tests and x-rays;
2. Pre-operative, operative and post-operative services;
3. Ancillary Charges;
4. Emergency room in cases of Medical Emergency; or
5. Emergency room in cases other than Medical Emergencies.

Surgical Expenses. Surgery includes the Medically Necessary preoperative and post operative care, when performed by a Physician. Services are subject to Precertification review procedures as detailed in Section 5. If two (2) or more operations or procedures are performed on the same day, on the same patient, by the same Physician, benefits are described in the Schedule of Benefits and are subject to the Usual, Customary and Reasonable Charges, or other negotiated rate, for the first procedure, and **50%** of Usual, Customary and Reasonable Charges, or other negotiated rate, for any additional procedures.

Surgical Assistance Service. Medically Necessary service of one (1) Physician who actively assists the operating surgeon when a covered Surgery is performed in a Hospital, and when such surgical assistance service is not available by an intern, resident or house Physician. The Plan provides benefits equal to **20%** of Usual, Customary and Reasonable Charges, or other negotiated rate, for any additional procedures.

Anesthesia Service. Service rendered by a Physician or a certified registered nurse anesthetist, other than by the attending surgeon or his assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration. Additional benefits are not provided for preoperative Anesthesia consultation.

Outpatient Surgery. A Participant receiving services in a Hospital, but not admitted as a registered bed-patient, is entitled to a benefit equal to the Hospital's regular charges for the services furnished him, but only for the following:

1. Use of the Hospital's facilities and equipment for Surgery, including X-ray and lab services provided on the same day as Surgery;
2. Use of the Hospital's facilities and equipment for radiation therapy, inhalation therapy and physical therapy;
3. Elective abortions;
4. Sterilization procedures for participating Employees, Retired Employees and participating Spouses, but not including Surgery for the reversal of sterilization;
5. Oral Surgery (limited to the following procedures):
    a. Excision of tumors or cysts from the mouth;
    b. Apicoectomy (excision of tooth root without extraction of tooth);
    c. Cutting procedures on the gums and mouth tissues for treatment of disease;
    d. Osseous surgery;

e. Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures);
f. Treatment of fractures of facial bones;
g. External incision and drainage of cellulites; and
h. Incision of accessory sinuses, salivary glands or ducts.

Professional Services.

1. Physician services for performing or assisting in the performance of Surgery or an obstetrical procedure, home, office and Hospital visits and other Medical Care and treatment;
2. Anesthesia and its administration;
3. Diagnostic X-ray or laboratory examinations and their interpretation;
4. Outpatient pre-admission testing;
5. Maternity Benefits;
    a. Expenses for participating Employees, Retired Employees, participating dependents;
    b. Expenses are covered on the same basis as Sickness;
    c. Birth Center services or Nurse-Midwives/Practitioners for Medically Necessary services in connection with delivery of a Child or Children provided in state certified Birth Centers. The Nurse-Midwife/Practitioner must be licensed for the nature of services provided by the state he or she is operating in;
    d. Inpatient charges for a newborn baby for routine nursery room and board and for routine professional services required for the newborn. Routine nursery benefits are limited to the period of the mother's confinement and will be considered for payment as an eligible expense under the newborn Participant when added to the Plan (see Special Enrollment Rights).
6. Manipulative therapies/massage (limited to 12 visits per calendar year, combined benefit).
7. Therapeutic Treatment:
    a. Physiotherapy provided by a Physician, Hospital or legally qualified physiotherapist;
    b. Speech therapy by a qualified speech therapist; **(required because of an Injury or Sickness other than a functional nervous disorder; provided, however, if therapy is required because of a congenital anomaly, the Participant must have had corrective Surgery before the therapy. Expenses related to special educational needs are not covered);**
    c. Radiation therapy;
    d. Respiratory therapy; and
    e. Rehabilitative therapy.

Mental/Nervous Disorders and Drug/Alcohol Abuse Treatment. The Plan will pay eligible expenses for Inpatient and Outpatient treatment of mental/nervous disorders and

drug/alcohol abuse as detailed in the Schedule of Benefits. **The unpaid balance of these expenses will not count toward the maximum Out-of-Pocket Limit.**

The maximum amount payable on account of all Covered Medical Expenses incurred with respect to any one (1) Participant is listed in the Schedule of Benefits.

The provisions concerning mental/nervous disorders and drug/alcohol abuse apply only to services resulting from diagnosis or recommendation by a Physician and only to expenses to the extent that they are for treatment recognized by the medical profession as appropriate methods of treatment in accordance with broadly accepted standards of medical practice, taking into account the current condition of the individual. Expenses incurred for treatment of mental/nervous disorders and drug/alcohol abuse will be considered as Covered Medical Expenses only as provided above.

***Eligible providers are licensed psychiatrists or psychologists, or licensed mental health counselors working under the direct supervision of a licensed doctor of medicine (M.D.)**

Home Health Care Expenses. Charges by a Home Health Care Agency for visits furnished to a Participant in such person's home in accordance with a Home Health Care Plan are eligible if:

1. The attending Physician certifies that:
2. Hospitalization or confinement in an Extended Care Facility would otherwise be required if home care were not available;
3. Medically Necessary Care and treatment are not available from members of the Participant's immediate family or other person residing with the Participant without causing undue hardship; and
4. The services are provided by or coordinated by a Home Health Care Agency.
5. The following services and supplies are covered:
    a. Nutrition counseling provided by or under the supervision of a registered dietitian;
    b. Part-time or intermittent nursing care by a Licensed Practical Nurse;
    c. Physical, respiratory, or speech therapy; and
    d. Medical supplies, drugs and medications prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, if such supplies and services would be covered under the Plan if the Participant were Hospital confined.
6. The Home Health Care benefit shall not cover:
    a. Services or supplies not approved by the Utilization Review Service;
    b. Services rendered in any period during which the Participant is not under the continuing care of a Physician;
    c. Services of a person who ordinarily resides in the Participant's home or is a member of the family of the patient/Participant;
    d. The services of any social worker;
    e. Transportation services;

f. Custodial Care; and
g. Care for a Child or family while caretaker is ill.

7. **The maximum number of Home Health Care visits per Participant that will be covered in any one (1) calendar year is forty (40).** Each visit by a home health aide of up to four (4) consecutive hours in a twenty-four (24) period shall be considered as one (1) Home Health Care visit.

Hospice benefits.

1. Period of Bereavement. A period beginning on the date of death of the terminally ill or hospice patient and ending six (6) months after.

2. Terminally Ill Patient. A Participant with a life expectancy of six (6) months or less as certified in writing by the attending Physician.
   a. In order to be eligible for this hospice benefit, the terminally ill patient must be confined in a Hospital for at least three (3) days in connection with the terminal illness immediately prior to participating in a hospice program. The hospice benefit pays Usual, Customary and Reasonable Charges, provided such charges are incurred during the period of participation in the Plan or a Period of Bereavement. Covered Medical Expenses must be incurred for services provided for the family unit of the Participant under the Hospice program of care that are rendered by a Hospice Care Agency or other facility on behalf of the Hospice Care Agency.
   b. Covered Hospice Expenses include:
      (1) Inpatient hospice care;
      (2) Physicians' services;
      (3) Bereavement counseling
      (4) Home Health Care services, including;
         - Part-time nursing care rendered in the Participant's home;
         - Physician's visits to the Participant's home;
         - Physical therapy provided in the Participant's home
         - The use of medical equipment;
         - The rental of wheelchairs and Hospital type beds;
         - Emotional support services of a Physician or social worker;
         - Drugs and medication; and
         - Homemaker services.

Mammograms. Routine mammograms with or without a Physician's prescription, if the mammogram is obtained in an office, facility or other health testing service that uses radiological equipment registered with the Department of Health and Human Services for breast cancer screening, limited to the following:

- One baseline mammogram for each individual from age 35 through 39;

- One routine mammogram every 2 years for each individual from age 40 through 49 (more frequent mammograms will be covered when recommended and prescribed by a physician);
- One routine mammogram per calendar year for each individual age 50 and over.

Infertility Testing. Covered charges are limited to those diagnostic procedures and related expenses (including x-ray and laboratory examinations) performed solely to determine the cause of the infertility.

Nursing Care.

1. Registered Nurse (RN);
1. Licensed Practical Nurse (LPN); and
2. Advanced Registered Nurse Practitioner (ARNP).

Prescription Drugs as provided by the Pharmacy Benefit Manager.

Other Eligible Medical Expenses.

1. Local professional ambulance service for necessary transportation due to an accident or life threatening emergency or for treatment which cannot be performed at the Hospital in which the patient is confined. Air ambulance, if determined to be Medically Necessary, to the nearest facility where care can be provided;
2. Biofeedback if the services are provided by a Physician for a Medically Necessary covered condition;
3. Medically Necessary charges for Gastric Bypass Surgery:
   Before proceeding with a gastric procedure, the Participant shall be actively engaged in a disease management program for obesity for a minimum of six (6) months. This program should be supervised by a Physician and include nutrition and exercise, including dietitian consultation, low calorie diet, increase physical activity and behavioral modification. This program must be documented in a medical record including:
   a. Regular monthly Physician visits;
   b. Participation in nutrition and exercise program that is supervised by a Physician working in cooperation with dietitians and/or nutritionists;
   c. Healthy activity with supervised exercise three (3) to five (5) times a week;
   d. Participation in a nutrition and exercise program must occur within the two (2) years prior to Surgery.

   If the Participant fails to achieve a 10% reduction in BMI, he/she may be eligible for the Gastric Bypass Surgery if BMI >35 with co-morbidities or BMI >40;
4. Surgical Preparation:
   a. The Participant must enter a dedicated bariatric program with dietary/nutrition and psychological/psychiatric preoperative evaluation;
   b. The program must address long-term lifestyle management;
   c. The need for the Surgery must be documented by a Physician other than

the surgeon for the bariatric procedure;

d. Weight loss dietary and exercise program must occur for a minimum of six (6) months or longer, must be within the two (2) years prior to Surgery and must be documented in a medical record, not a summary letter from the Physician;
e. Morbid Obesity must have existed for five (5) years prior to surgical consideration as documented by Physician records;

5. Allergy injections and allergy surveys;
6. Necessary Durable Medical Equipment (see Section 5 – Requirements for Pre-Certification) rental, up to the amount of purchase of such equipment. Repairs are covered if deemed to be more cost effective than a new purchase.
7. Wellness Care as described in Section 7;
8. Transplants are reviewed with regard to Medical Necessity, the facility's recommendations and Physician documentation;
   Any services and supplies that are required for donor/procurement as a result of a surgical transplant procedure for a Participant will be provided up to the maximum limitation listed in the Schedule of Benefits. This limitation applies to all donor/procurement charges. Benefits for such charges, services and supplies are not provided under this provision if benefits are provided under another group plan or any other group or individual contract or any arrangement of coverage for individuals in a group (whether an insured or uninsured basis), including any prepayment coverage;
9. Confinement in a rehabilitation facility up to the number of days detailed in the Schedule of Benefits. Confinement in the facility must follow within forty-eight (48) hours of and be for the same or related cause(s) of a period of Hospital or Extended Care Facility confinement;
10. Pain management for chronic pain must be Medically Necessary and rendered by a covered Physician. Pain is chronic if it has occurred recurrently over months or years or persists longer than expected following an illness or Injury. Typically, pain is not considered chronic until it has persisted for three (3)-six (6) months or more. Multiple disciplinary pain management assessment and the submission of a treatment plan following the initial evaluation by a pain Physician will be required for pain management services; and
11. Medically Necessary Care and treatment.

Section 7 – Routine Well Care

Well Child Care

Should your Eligible Dependent Child incur any of the following routine health services, the deductible will be waived and the regular Co-payment percentage of the Plan will be paid.

Frequency of routine child care examinations. Benefits, except for immunizations, are limited to one visit payable to one provider for all specified services at approximately the age intervals listed below:

Birth	9 months	2 years	6 years
2 months	12 months	3 years	8 years
4 months	15 months	4 years	10 years
6 months	18 months	5 years	12 years

Covered Services. Covered routine Physician and Laboratory services are limited to the following:

1. History,
2. Physical exam,
3. Anticipatory guidance,
4. Immunizations, including the heptavax vaccine, will be covered regardless of when the immunization is administered, and
5. Laboratory tests deemed appropriate by the examining physician during the course of a routine physical exam.

Well Adult Care

Routine Well Care* (age 18 and over)

1. Limited to a maximum payable of $400 per year for Covered Services (see below) every 24 months under age 40.
2. Limited to a maximum payable of $400 per year for Covered Services (see below) every 12 months age 40 and over.

***Must have a routine diagnosis to be covered under Well Care. Maximum payable of $400 is not subject to the Deductible or the regular Co-payment percentage of the Plan.**

Covered Services. Covered routine Physician and Laboratory services are limited to the following:

1. Physical Exam
2. Laboratory tests and x-rays deemed appropriate by the examining physician during the course of a routine physical examination
3. Immunizations
4. Gynecological Exam (including pap smear and related lab fees)
5. Mammograms (refer

Section 8 – Medical Exclusions

Exclusions and Limitations. The following services or charge shall **not be** considered Covered Medical Expenses under the Plan in any event:

1. Charges relating to any Pre-Existing Condition, pursuant to the provisions set forth in Section 3;
2. Transportation charges other than by a professional ambulance service;
3. Services or supplies which constitute personal comfort or beautification items, television or telephone use, or in connection with Custodial Care, education or training or expenses actually incurred by other persons except specifically addressed under Covered Medical Expenses;
4. Services needed due to war or any act of war, whether declared or undeclared;
5. Services rendered resulting from or occurring during the commission of a crime or while engaged in an illegal act. Exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence;
6. Charges for services incurred outside the continental United States unless charges were incurred while traveling on business or for pleasure, or in the case of a full time student, while traveling abroad;
7. Services rendered which are eligible for payment or coverage by any other plan that does not provide coordination of benefits. This Plan pays secondary to such other plan;
8. Services, care, treatment, and referrals rendered by the Participant's family including, but not limited to, mother, father, grandmother, grandfather, aunt, uncle, cousin, brother, sister, son, daughter, grandson, granddaughter, or any person who resides with the Participant;
9. Services rendered for treatment of any Sickness or Injury for which benefits are available under the workers' compensation employer liability law or services for any Occupational Sickness or Injury. Occupational Sickness or Injury includes those as a result of any work for wage or profit;
10. Charges for completion of claim forms;
11. Charges billed by both Physician and Hospital for the same service (except for charges for Anesthesia which shall be paid to the Hospital and to the Physician based upon Usual, Customary, and Reasonable Charges);
12. Expenses in excess of the Usual, Customary, and Reasonable Charges;
13. Education classes, including charges for natural childbirth instruction;
14. Services performed for cosmetic or reconstructive Surgery or complications of cosmetic or reconstructive Surgery procedures unless:
    a. The condition is necessary as the result of Accident or Sickness;
    b. Scar revision due to Accident or Sickness;
    c. Corrections or congenital defects which interferes with bodily function;
    d. The services are performed during the period of a Participant is participating under the Plan; and
    e. The services are for reconstruction of the breast on which a mastectomy

was performed, Surgery and reconstruction of the other breast to achieve symmetry in appearance and necessary prosthesis or physical complications at any stage of mastectomy, including lymphedemas. These procedures shall be performed in a manner determined in consultation with the patient and the patient's attending Physician.

15. Any related expenses for a procedure not covered by the Plan;
16. Charges which are payable by any third party due to legal liability including, but not limited to, professional liability insurance, motor vehicle liability insurance, individual liability insurance, any other source form which medical benefits would be paid of this Plan did not exist, whether or not legal action is taken on behalf of the Participant;
17. Charges which the Participant would not be required to pay if he did not have group health coverage;
18. Charges to the extent of coverage required by, or available through, any federal, state, municipal or other governmental body or agency, except for medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act ("Medicaid");
19. Experimental/Investigative drugs, chemicals, services or procedures;
20. Services provided by an entity not defined as an eligible Provider;
21. Sexual conversion Surgery, sexual dysfunction, or other services related to gender reassignment or disturbance of gender identification;
22. Music therapy, vision therapy or remedial reading therapy or treatment for learning disabilities;
23. Exercise equipment including bicycles, weights, ergometers, or other equipment not generally considered Durable Medical Equipment;
24. Charges and services related to a newborn who is not a participating Dependent;
25. Sterilization expenses for Eligible Dependent Children;
26. Sterilization reversals;
27. With respect to diagnostic testing:
    a. Tests performed more frequently than is necessary according to the diagnosis and accepted medical practice;
    b. Genetic testing unless family history necessitates;
    c. Premarital examination;
    d. Duplicate testing by different Physicians unless a Second Opinion is authorized herein and;
    e. Tests associated with routine visits except those covered under the Wellness benefit provision.
28. With respect to consultations:
    a. Telephone only consultations;
    b. Consultants for ineligible or unnecessary procedures; and
    c. Services rendered by practitioners other than Physicians;
29. With respect to infertility:
    a. Invitro or invivo fertilization, artificial insemination, or any other impregnation procedure;
    b. Fertility drugs;
    c. Any treatment other than that which treats a medical condition;

d. Diagnostic tests unless necessary to diagnose a medical condition or performed solely to determine the cause of the infertility; and
e. Fertility supplies, treatment or counseling;

30. With respect to Hospital services:
    a. Room and Board Charges made by a facility other than a Hospital or Extended Care Facility;
    b. Admission for observation, rest, physical therapy, or testing;
    c. Weekend admissions except for Medical Emergencies;
    d. Charges for any period of confinement prior to the day before scheduled Surgery unless a documented hazardous medical condition exists; and
    e. Charges deemed not Medically Necessary by the Utilization Review Service and/or Claims Administrator;
31. Transplant expenses incurred for donor procurement to the extent exceeding the limits set forth in the Schedule of Benefits and Covered Medical Expenses;
32. Visual acuity testing, visual correction other than cataract removal, by any means, including radial keratotomy, lasik Surgery and other Surgeries, exercise, eyeglasses, contact lenses, or orthoptic training;
33. Replacement of prosthetic devices, except when required because of growth or other physiologic change or a change in the Participant's condition;
34. Penile implants and/or any related expenses unless having organic origin;
35. Arch supports and orthopedic shoes (except those forming an integral part of a corrective brace);
36. Orthotics, unless deemed Medically Necessary by the Claims Administrator, orthopedic shoes or other supportive devices for the feet;
37. Care and treatment (excluding Medically Necessary Gastric Bypass Surgery) of any type of obesity, including Morbid Obesity, weight loss programs, exercise programs, medications and/or dietary consultations. This exclusion is applicable whether or not it is solely for the treatment of obesity or if a part of the treatment for another Sickness. Counseling services necessary related to eating disorders (ex. anorexia, bulimia) will be provided as detailed under the mental/nervous benefits;
38. Smoking cessation and any related services including nicorettes, patches (Nicoderm/Habitrol, etc.)'
39. Hearing aids, implants, routine hearing testing or services necessary due to degenerative hearing loss not specifically caused by Sickness, congenital defect or trauma;
40. Acupuncture, hypnotherapy;
41. Medical care claims filed more than fifteen (15) months from the date of service;
42. For any prescriptions covered under the drug card program;
43. Services due to intentional self-inflicted Injuries unless due to a medical condition (either physical or mental or domestic violence);
44. Care and treatment that is deemed not Medically Necessary;
45. Marital and family counseling;
46. Surrogate parenting;
47. Taxes, postage, shipping and handling;
48. For removal of excess skin unless Medically Necessary.

Section 9 – Coordination of Benefits

Because the sole purpose of health care coverage is to help meet actual medical expenses, nearly all group health plans contain a "coordination of benefits" requirement. Coordination of Benefits applies to any situation in which you (or any of your Eligible Dependents) are also eligible for coverage under any other health plan. It means that you and/or your Eligible Dependents covered under the Plan and any other health plan could be reimbursed up to 100% of your covered expenses.

In the interest of controlling costs, no one can be permitted to profit from an illness or Accident. Therefore, under no circumstances will you be reimbursed for more than the total amount of the expenses you actually incurred.

If you are covered by more than one plan of health benefits, one of the plans is considered to be "primary" and pays for your covered expenses up to the limits of its benefits. The other plans are considered "secondary" and pay the remaining covered expenses you may have, up to the limits of their benefits.

If a Participant is covered by two (2) eligible plans (one (1) of which is this Plan) and both plans have a provision for coordination of benefits, the amount each plan pays and the order of payment of benefits will be as follows:

1. The plan covering the Participant as an Employee is the primary plan;
2. The plan covering the Participant as a Dependent is the secondary plan;
3. If the parents of a participating dependent Child are not divorced and the dependent Child is covered under both plans as a Dependent, the primary plan will be the one which covers the individual as a Dependent of the parent whose birthday falls earlier in the Calendar Year, irrespective of the year of birth;
4. If the parents of a participating dependent Child are divorced and the parent having custody of the dependent Child has not remarried, the benefit plan of the parent having Child custody shall be considered as the primary plan;
5. If the parents of a participating dependent Child are divorced and the parent having custody of the dependent Child has remarried:
    a. The plan covering the dependent Child of the parent with custody shall be primary;
    b. Then the plan covering the Child as a Dependent of a Spouse of the parent with custody shall be secondary;
    c. Third, the plan of the parent without custody shall apply.
6. Notwithstanding Numbers 4 & 5 of this Section, if there is a Qualified Medical Child Support Order which establishes the financial responsibility of a parent for health care expenses for the Child, that parent's plan shall be considered as the primary plan;
7. If joint custody does not establish responsibility for health care of a participating dependent Child, the primary plan will be the one (1) which covers the dependent

Child as a Dependent of the parent whose birthday falls earlier in the Calendar Year, irrespective of the year of birth;

8. Except as provided in Numbers 3 through 7 of this Section, the plan which covers a person as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before those of a plan which covers that person as a laid off or Retired Employee or as that Employee's Dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored;
9. If Numbers 1 through 8 of this Section does not apply, the plan which has covered the individual for the longest period of time will be considered as the primary plan;
10. Notwithstanding any provision herein to the contrary except Number 6 of this Section, in the event coverage by a plan does not provide for the coordination of benefits, that plan will be considered the primary plan, and this Plan is considered the secondary plan; and
11. Auto coverage required by a motor vehicle accident reparations act (no fault auto plan) or similar law will be considered primary.

Payment of Benefits. If this Plan is primary, it will pay benefits as outlined. If this Plan is secondary, benefits will be calculated per the Plan's provisions after receipt of the primary payor's explanation of benefits.

Right to Receive and Release Necessary Information. For the purpose of determining the applicability of and implementation of these provisions under the Plan, the Claims Administrator may, without notice to or consent from you, release to or obtain from another insurer or organization any information deemed to be necessary for the purpose of coordinating benefits. Any individual claiming benefits under the Plan must furnish to the Claims Administrator such information regarding other coverage which may be applicable as may be necessary to properly adjust the claim.

Facility of Payment. Whenever payments which should have been made under the Plan in accordance with the Coordination of Benefits provisions have been made under any other plans, the Plan Administrator shall have the right to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of these provisions and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Plan Administrator shall be fully discharged from liability under this Plan.

Right to Recovery. Whenever payments have been made by the Claims Administrator with respect to Covered Medical Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary to satisfy the intent of these provisions, the Plan Administrator shall have the right to recover such payments, to the extent of such excess, from one or more of the following:

1. an individual to or for or with respect to whom such payments were made; or
2. an insurance company; or
3. any other organization.

Section 10 – How to File a Claim

Claims Processing Procedures. This section describes in detail what to do in order to receive benefits under this Plan. The Employee should contact the Employee Benefits Office for additional information.

Claims should be mailed to the address indicated on the back of the Employee's identification card(s).

Filing Claims. A Participant must file a written claim for benefits under the Plan with the Claims Administrator no later than fifteen (15) months from the date of service. The written claim shall be made on such form(s) as may be prescribed from time to time by the Claims Administrator and shall include such information as requested on the claim form.

Review Procedures. If a Participant is notified of an adverse benefit determination, the Participant or his or her authorized representative may make a written request for review of the determination by submitting such request to the Claims Administrator, c/o Acordia National, P. O. Box 366, Charleston, WV 25322, within 180 days after notification of the adverse benefit determination, except in the case of any reduction or termination of a course of treatment (other than by Plan amendment) ***before*** the end of the previously approved period or number of treatments, the Claims Administrator will provide the Participant sufficient advance notice of the reduction or termination to allow the Participant to appeal and obtain a determination before the benefit is reduced or terminated (which period is not required to be 180 days).

A Participant's written request for review will be forwarded by the Claims Administrator to the Plan Administrator for a full and fair review. The Participant will be provided the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. The Participant will also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits. The Plan Administrator will conduct its review without deference to the initial benefit determination and taking into account all comments, documents, records and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment , including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the Plan Administrator will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor a subordinate of such individual. The Plan Administrator will also provide for the identification of medical or vocational

experts whose advice was obtained on behalf of the Plan in connection with a Participant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

In the case of a claim involving urgent care, the Plan Administrator will provide for an expedited review process pursuant to which a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Participant and all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Participant by telephone, facsimile, or other available similarly expeditious method.

Notification of Benefit Determination on Review. The Claims Administrator will provide a Participant with written notification of the Plan's benefit determination on review. In the case of an adverse benefit determination, the notification will set forth the following:

1. Specific reason(s) for the adverse determination;
2. Reference to the specific Plan provisions on which the benefit determination is based;
3. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's claim for benefits;
4. A statement describing voluntary appeal procedures offered by the Plan.

If you have any questions about these claims or review procedures, please contact the Employee Benefits Office.

Section 11 - Subrogation, Reimbursement, and Equitable Lien

If you or your Eligible Dependents or anyone who receives benefits under the Plan is injured and entitled to receive money from any source, including but not limited to any party's liability insurance and uninsured/underinsured motorist proceeds, then the benefits provided or to be provided by the Plan are secondary, not primary, and will be paid only if the Covered Person fully cooperates with the terms and conditions of the Plan.

Subrogation. As a condition of participation in the Plan, you and your Eligible Dependents automatically assign to the Plan any rights you may have to recover all or part of any payments made by the Plan from any other party, including an insurer or another group health plan. Therefore, the Plan Administrator may act as your substitute in the event of any payment made by the Plan for medical benefits, including any payment for a pre-existing condition, is or becomes the responsibility of another party. Such payments shall be referred to as "Reimbursable Payments."

The Plan Administrator shall be subrogated to all your rights of recovery, or any individual who received a payment of funds on your behalf, against any insurance carrier(s) or any third party. All rights of recovery will be limited to the amount of any payments made under the Plan.

This assignment allows the Plan to pursue any claim that you may have, whether or not you choose to pursue that claim. If you claim benefits under the Plan, you shall execute and deliver such documents as may be required, and do whatever else is necessary, to secure such rights to the Plan.

If Subrogation conflicts with the laws of the State or governing jurisdiction, it shall not be enforced, and the Right of Reimbursement will apply.

Right of Reimbursement. If you or your dependent has received benefit payments from the Plan for Injury, Accident, or Sickness, and subsequently obtain a settlement from or a judgment (or any similar arrangement) against a third party payer who, because of circumstances, is liable for the health care costs, you are obligated to reimburse the Plan. The amount of reimbursement shall be equal to the benefit payments received under the Plan or the amount recovered, whichever is less.

This right of reimbursement applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the Covered Person constitute a full or a partial recovery, and applies not only to funds paid for medical charges, but also to any other amounts paid by such third party, whether by an insurer or otherwise, whether pursuant to judgment, settlement or otherwise, and shall include all amounts paid by such third party, including but not limited to, costs of collection, attorney fees, amounts designated for paid and suffering, and other damages.

If you or your dependent retains an attorney, then you or your dependent agrees to only retain one who will not assert the Common Fund or Made-Whole Doctrines. Reimbursement shall be made immediately upon collection of any sum(s) received regardless of its legal, financial or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

Equitable Lien. The Plan shall have an equitable lien against any rights the Covered Person may have to recover any payments made by the Plan from any other party, including an insurer or another group health plan. Recovery shall be limited to the amount of Reimbursable Payments made by the Plan. The equitable lien also attaches to any right to payment for workers' compensation, whether by judgment or settlement, where the Plan has paid expenses otherwise eligible as Covered Medical Expenses prior to a determination that the Covered Medical Expenses arose out of and in the course of employment. Payment by workers compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to the first right of recovery to any money or property that is obtained by anybody (including, but not limited to, the Covered Person, the Covered Person's attorney, and/or trust) as a result of an exercise of the Covered Person's right of recovery. The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such monies or properties. At the discretion of the Plan Administrator, the Plan may reduce any future Covered Medical Expenses otherwise available to the Covered Person under the Plan by an amount up to the total amount of Reimbursable Payments made by the Plan that is subject to the equitable lien.

General Provisions. The following provisions shall apply to the Plan's right of subrogation, reimbursement and creation of an equitable lien:

The subrogation, reimbursement, and equitable lien rights apply to any benefits paid by the Plan on behalf of the Covered Person as a result of the injuries sustained, including but not limited to:

1. Any no-fault insurance;
2. Medical benefits coverage under any automobile liability plan. This includes the Covered Person's plan or any third party's policy under which the Covered Person is entitled to benefits;
3. Under-insured and uninsured motorist coverage;
4. Any automobile Medical Payments and Personal Injury Protection benefits; and
5. Any third party's liability insurance.

In addition:

1. The Plan may make total payments that exceed the maximum amount to which the Covered Person is entitled at any time under the Plan. In the event of such payments the Plan shall have the right to recover the excess amount from any persons to, or for, or with respect to whom such excess payments were made.
2. The Plan provides that recovery of excess amounts may include a reduction from future benefit payments available to the Covered Person under the Plan of an amount up to the aggregate amount of Reimbursable Payments that have not been reimbursed to the Plan.
3. The provisions of the Plan concerning subrogation, reimbursement, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.
4. The reimbursement required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by the Plan Administrator in the exercise of its sole discretion.
5. The Employee or Covered Person agrees to sign any documents requested by the Plan including but not limited to reimbursement and/or subrogation agreements as the Plan or its agent(s) may request. Also, the Employee or Covered Person agrees to furnish any other information as may be requested by the Plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan. Any excess after 100% reimbursement of the Plan may be divided up between the Employee or Covered Person and their attorney if applicable. The Employee or Covered Person agrees to take no action which in any way prejudices the rights of the Plan.
6. The Plan Administrator has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary.
7. If the Employee or Covered Person takes no action to recover money from any source, then the Employee or Covered Person agrees to allow the Plan to initiate its own direct action for reimbursement.

Section 12 –Continuation Coverage Rights

COBRA Continuation Coverage. This Section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This Section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should contact the Employee Benefits Office.

What is COBRA Continuation Coverage? COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Eligible Dependent Children, Domestic Partner and your Spouse could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

1. Your Spouse dies;
2. Your Spouse's hours of employment are reduced;
3. Your Spouse's employment ends for any reason other than his or her gross misconduct;
4. Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your Spouse.

Your Eligible Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-Employee dies;
2. The parent-Employee's hours of employment are reduced;
3. The parent-Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as an "Eligible Dependent Child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed with respect to an Employer, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a Qualified Beneficiary with respect to the bankruptcy. The retired Employee's Spouse, surviving Spouse, and Eligible Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available? The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Employee Benefits Office has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, commencement of a proceeding in bankruptcy with respect to an Employer, or the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events. For the other qualifying events (divorce or legal separation of the Employee and Spouse or a child's losing eligibility for coverage as an Eligible Dependent Child), you must notify the Employee Benefits Office within 60 days after the qualifying event occurs. You must provide this notice to the Employee Benefits Office by submitting a properly completed Notice of Qualifying Event form.

How is COBRA Coverage Provided? Once the Employee Benefits Office receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee's becoming entitled to

Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a child's losing eligibility as an Eligible Dependent Child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and Eligible Dependent Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

1. **Disability extension of 18-month period of continuation coverage**

   If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Employee Benefits Office in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18month period of continuation coverage. You will be required to provide the Employee Benefits Office with a copy of the Social Security Disability award you receive from the Social Security Administration.

2. **Second qualifying event extension of 18-month period of continuation coverage**

   If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and Eligible Dependent Children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any Eligible Dependent Children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Child stops being an Eligible Dependent Child, but only if the event would have caused the Spouse or Eligible Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

Conversion Privileges. When you leave the Plan, or when continuation of coverage ends, any individual not eligible for Medicare may obtain a conversion policy on a direct pay basis, without evidence of insurability. This conversion privilege is also available to

your covered surviving dependents if you should die, and to a covered child whose benefits cease because s/he reaches the age limit or marries. Ask the Employee Benefits Office, for a health conversion application.

If you qualify for conversion, you must apply for the individual policy within 31 days from the date that your coverage under the Plan ceases.

Family and Medical Leave Act. Your coverage will be continued during an approved Family or Medical Leave. You will be required to make contributions to continue the coverage of your Eligible Dependents during such a leave. At the conclusion of such a leave, if you return to work, your coverage and your Eligible Dependents' coverage will be in force with no additional waiting period or preexisting condition limitation. If you do not return to work at the conclusion of such a leave and your employment is terminated, you will be eligible for continued coverage under this section of the Plan.

You must provide the Employee Benefits Office, with the documentation of such a leave at the onset of such a leave. This will insure proper continuation of benefits.

If you do not return to work following FMLA leave, you may be required to reimburse Monroe County for health insurance premiums paid to continue your health coverage during FMLA leave, unless you are unable to return to work due to a continuation, recurrence, or onset of a serious health condition that would entitle you to FMLA leave or other circumstances beyond your control.

USERRA. Under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), you have the right to continue coverage under the Plan if you leave your job to perform qualifying military service. Those rights are similar to your COBRA rights described above, with the following exceptions:

1. If eligible, your period of USERRA coverage can last for up to 24 months.
2. Your Eligible Dependents do not have an independent right to elect USERRA coverage.
3. Even if you do not elect to continue coverage during your period of military service, you have the right to be reinstated in the Plan when you are reemployed, generally without any waiting periods or exclusions (such as pre-existing condition exclusions) except for service-connected Illnesses or Injuries.

You must provide the Employee Benefits Office, with the documentation of such a leave at the onset of such a leave. This will insure proper continuation of benefits.

For more information on USERRA, contact VETS at 1-866-4-USA-DOL or visit its website at http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://dol.gov/elaws/userra.htm.

If You Have Questions. Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep the Plan Informed of Address Changes. In order to protect your family's rights, you should keep the Employee Benefits Office informed of any changes in the addresses of any covered person. You should also keep a copy, for your records, of any notices you send to the Employee Benefits Office.

Plan Contact Information.

Employee Benefits Office
1100 Simonton Street, Room 2-268
Key West, FL 33040
(305) 292-4446 (Lower Keys)
(305) 743-0079, ext. 4446 (Middle Keys)
(305) 852-1469, ext. 4446 (Upper Keys)

Section 13 - Qualified Medical Child Support Orders

How Will the Plan administer a Qualified Medical Child Support Order (QMCSO)? The Plan will provide benefits as required by any Qualified Medical Child Support Order. A Qualified Medical Child Support Order (QMCSO) can be either:

1. A Medical Child Support Order (MCSO) that satisfies the requirements of Section 609(a) of ERISA; or
2. A National Medical Support Notice (NMSN) that satisfies the requirements of Section 1908 of the Social Security Act.

What are a Medical Child Support Order and a National Medical Support Notice? An MCSO is a judgment, decree or order (including a domestic relations settlement agreement) issued by a court of competent jurisdiction that provides for child support for the Participant's child, or directs the Participant to provide health coverage under a health plan in compliance with state domestic relations law (including community property law). A medical child support order may also be a judgment, decree or order issued by a court of competent jurisdiction that enforces medical child support as required by Section 1908 of the Social Security Act.

An NMSN is a notice issued by a state or local government agency which is similar in form, content and legal effect to a court issued MCSO which directs a health plan to provide coverage for the dependent child of a non-custodial parent. The NMSN must be issued pursuant to a domestic relations order which requires provision of health care coverage for a dependent child.

What is needed for a Medical Child Support Order (MCSO) or a National Medical Support Notice (NMSN) to be a Qualified Medical Child Support Order (QMCSO)? In order for an MCSO or NMSN to be a Qualified Medical Child Support Order, the order (or notice) must create or recognize an Alternate Recipient to receive coverage under the health plan. An Alternate Recipient is any child of a Participant who is recognized by an MCSO or NMSN (and specifically named in the order or notice) as having the right to enroll in the group health plan. In order to be qualified the MCSO or NMSN must also specify:

1. The name and last known address of the Participant;
2. The name and last known address of each Alternate Recipient;
3. A reasonable description of the type of coverage to be provided to each Alternate Recipient or the manner in which the type of coverage is to be determined;
4. The period of coverage; and
5. The name of the health plan.

An order (MCSO) or notice (NMSN) is not qualified if it requires any type of benefit not otherwise available to the Participant. This does not apply if the type of coverage is required by Section 1908 of the Social Security Act.

What steps must the Participant take when a Medical Child Support Order (MCSO) is received? The Participant must notify the Employee Benefits Office within 30 days after receipt of an MCSO. The Participant must also complete any necessary forms and provide any reasonable information or assistance that the Employee Benefits Office requests in connection with the MCSO.

What will the Employee Benefits Office do when it receives a Medical Child Support Order (MCSO) from the Participant or a National Medical Support Notice (NMSN) from a government agency? When the Employee Benefits Office receives an MCSO from a Participant or an NMSN from a government agency, the Employee Benefits Office will:

1. Notify the Participant and each Alternate Recipient, in writing, of the Plan's procedures for determining if the order or notice is a Qualified Medical Child Support Order;
2. Make a determination of the qualified status of the order or notice within a reasonable time;
3. Notify the Participant and each Alternate Recipient, in writing, of the Plan's determination; and
4. If the notice is a NMSN, notify the applicable government agency of its determination within a reasonable period of time (not to exceed 40 business days).

If the notice is an NMSN, the Employee Benefits Office will also notify the government agency that issued the notice:

1. Whether or not coverage is available to the Alternate Recipient;
2. Whether or not the Alternate Recipient is enrolled;
3. What coverage options are available to the Alternate Recipient;
4. The effective date of coverage; and
5. What steps the custodial parent (or agency) must take to obtain coverage.

When the Employee Benefits Office determines that the order or notice is a Qualified Medical Child Support Order (QMCSO), the Employee Benefits Office will determine the effective date of coverage and enroll each Alternate Recipient as required by the order and make any necessary deductions from the Participant's paychecks.

Section 14 – The Health Insurance Portability and Accountability Act (HIPAA)

Use and Disclosure of Protected Health Information (PHI). The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. The provisions of this Section 17 (and other provisions of the Plan relating to the HIPAA privacy rules) shall be effective on April 14, 2003, or such later date as may be provided by federal law or regulation.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits which related to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);
2. Adjudication of health benefit claims (including appeals and other payment disputes);
3. Subrogation of health benefit claims;
4. Establishing employee contributions;
5. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
6. Billing, collection activities and related health care data processing;
7. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
8. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
9. Medical necessity reviews or reviews of appropriateness of care or justification of charges;
10. Utilization review, including Preadmission Certification, preauthorization, concurrent review and retrospective review;
11. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
12. Reimbursement to the Plan.

Health Care Operations include, but are not limited to, the following activities:

1. Quality assessment;
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
3. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvements of payment methods or coverage policies;
7. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements;
8. Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
9. Resolution of internal appeals; and
10. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

The Plan May Use and Disclose PHI for Treatment, Payment and Operations, as Required by Law and as Permitted by Authorization of the Participant or Benefit.
The Plan may, without the consent or authorization of the individual, use and disclose PHI for health care treatment, health care payment, and health care operations, and for such other uses or disclosures to the full extent permitted by regulations promulgated by the Secretary of Health and Human Services to implement HIPAA, subject to more stringent state privacy laws which do not conflict with HIPAA (if any).

The Plan may also disclose PHI to such other persons and for such other purposes when authorized by the individual on a form and in a manner provided for in regulations promulgated by the Secretary of Health and Human Services to implement HIPAA.

The Plan may also disclose summary health information to the BOCC or the Employer if requested by it for the purpose of obtaining bids from health plans for providing health insurance coverage, or for modifying, amending or terminating the Plan. The Plan may also disclose information on whether the individual is participating in the group health plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions. The BOCC agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
2. Ensure that any agents, including a subcontractor, to whom BOCC provides PHI agrees to the same restrictions and conditions that apply to BOCC with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the BOCC unless authorized by an individual;
5. Make PHI available to an individual in accordance with HIPAA's access requirements;
6. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
7. Make available the information required to provide an accounting of disclosures;
8. Make internal practices, books and records relating to the use and disclosure of PHI available to the HHS secretary for the purposes of determining the Plan's compliance with HIPAA; and
9. If feasible, return or destroy all PHI received that the BOCC still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

Section 15 – General Provisions

Administration. The Plan Administrator shall be in charge of and responsible for the operation and administration of the Plan. The Employer is responsible for forwarding your application, enrollment card and other required documentation to the Employee Benefits Office, for forwarding to the Claims Administrator.

Funding. The Plan is funded by contributions from the Employers, the BOCC and you.

Assignment. Benefits provided for by this Plan shall not be assignable, however, subject to the written direction of you or your Spouse, all or a portion of the benefits provided may be paid directly to the provider of service, but is not required that the service be rendered by any particular provider.

Proof of Claims. The payment of any benefit in the Plan is subject to the provision that you are responsible to furnish proof of claim and releases as the Claims Administrator may reasonably require.

Proof of claim must be given to the Claims Administrator not later than 15 months after the covered expense is incurred by you or your Eligible Dependents. If you fail to provide proof of claim within the time specified, you will not be entitled to payment of your Covered Medical Expenses unless your failure was due to circumstances beyond your control.

Proof of Claim will consist of a completed claim form, an itemized bill or invoice from the provider of the service and any other documentation reasonably required by the Claims Administrator.

Facility of Payment. If you or your Eligible Dependents, in the opinion of the Employee Benefits Office, are legally incapable of giving a valid receipt for any payment due you and no guardian has been appointed, the Employer may, at its option, make such payment to the individual who has, in the Employer's opinion, assumed the care and principal support of such person. If you or your Eligible Dependents should die before all amounts due and payable have been paid the Plan Administrator may, at its option, make such payment to the executor or administrator of the estate or to the surviving Spouse or to any other individual who is equitably entitled thereto.

Any payment made by the Claims Administrator in accordance with these provisions shall fully discharge the Plan Administrator to the extent of such payments.

Nondiscrimination. The Plan Administrator will act so as not to discriminate unfairly between individuals in similar situations at the time of the action.

Plan. The Plan document governs all of the Plan's provisions. All statements made by the Employer, Plan Administrator or Employee Benefits Office, or employees thereof, shall be deemed representations and not warranties. In the event a statement made by the Employer, Plan Administrator, the Employee Benefits Office, or any employee thereof, conflicts with the terms of the Plan, the terms of the Plan shall control.

The Plan Administrator has the discretionary authority to make decisions regarding eligibility for benefits under the Plan and to construe and interpret the provisions of the Plan.

Contributions. If contributions are payable monthly, any coverage becoming effective will be charged from the first day of the calendar month coinciding with or next following the date the coverage takes effect, and contributions for any coverage terminated will cease as of the last day of the month coinciding with, or next following the date coverage terminates.

Clerical Error. Any clerical error (by the Employer, Plan Administrator or the Claims Administrator) in keeping pertinent records, or a delay in making any entry, will not invalidate coverage otherwise valid or continue coverage otherwise validly terminated or otherwise modify the Plan. An equitable adjustment may be made in the Plan Administrator's sole discretion when the error or delay is discovered.

Misstatements. If any relevant fact as to coverage has been misstated, an equitable adjustment will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under this Plan and its amount.

Severability. In the event that any provision of the Plan shall be held to be illegal or invalid for any reason by a court of competent jurisdiction, such illegality or invalidity shall not affect the remaining provisions of the Plan and the Plan shall be construed and enforced as if such illegal or invalid provision had never been contained in the Plan.

Protection against Creditors. To the extent permitted by law and except as otherwise provided in this Section, no benefit payment under the Plan shall be subject in any way to alienation, sale, transfer, assignment, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void.

No Employment Contract. Nothing in the Plan shall confer any rights of continued employment to any employee of the Employer or in any way alter an employee's status as a terminable, at-will employee of the Employer. Furthermore, the Plan does not constitute a contract of employment.

No Vesting. The benefits provided under the Plan to Covered Persons are neither guaranteed nor vested benefits.

Recovery of Benefit Overpayment. If any Plan benefit paid to or on behalf of a Covered Person should not have been paid or should have been paid in a lesser amount, and the Covered Person (or legal representative of a minor or incompetent) fails to repay the amount promptly, the overpayment may be received by the Plan from any monies then payable, or which may become payable, in the form of salary or benefits payable under any of the BOCC's or Employer's sponsored benefit plans or programs including the Plan. The Plan Administrator may also reduce future benefit payments on behalf of you or your Eligible Dependents until the amount of the overpayment has been fully offset. The Plan Administrator also reserves the right to recover any such overpayments by appropriate legal action.

Headings. The headings of the Plan are for reference only and shall not determine the interpretation or construction of the Plan.

Multiple Counterparts. The Plan may be executed in multiple counterparts, each of which will have the same force and effect.

Applicable Law. The Plan shall be construed and administered in accordance with the laws of the State of Florida.

Liability of Directors, Officers, and Employees. To the extent permitted by law, no director, officer, or employee of the Employer or Plan Administrator shall incur any personal liability of any nature for any act done or omitted to be done in good faith in connection with his duties relative to the Plan, except in cases of dishonesty, gross negligence or willful misconduct. Such directors, officers and employees of the Employer or Plan Administrator shall be indemnified and held harmless by the Employer or Plan Administrator from and against any liability, including reasonable attorneys' fees, to which any of them may be subjected by reason of any such good faith act or conduct in their director, officer, or employee capacity. Any indemnification payments made by reason of this provision shall not be made from the assets of the Plan nor any Trust established in connection with the Plan.

Medicare. Almost all individuals age 65 or over and certain individuals who are totally disabled or have permanent kidney failure can participate in Medicare by enrolling at any Social Security office. If you have earned the required number of quarters for Social Security benefits within the required time frame, you are **entitled** to Medicare Part A at no cost. Medicare Part B is optional. You may purchase Part B, paying the full cost.

<u>Active Employees and their Dependents</u>:
If you are an active employee age 65 or over, Federal law requires that you receive the same benefits as individuals under age 65, if you elect this option. The Federal law also requires that if you are an active employee, **regardless of your age**, and your spouse is 65 or over, your spouse must be offered the same benefits offered to active individuals, if your spouse elects this option.

Retirees over age 65, End Stage Renal Disease and/or Total Disability:
The benefits of this Plan will be coordinated with Medicare if:

1. You are an active employee and you or your Eligible Dependent is entitled to receive Medicare benefits by reason of permanent kidney failure (end stage renal disease); or
2. You are a retired employee under age 65 and you or your Eligible Dependent is entitled to receive Medicare benefits by reason of total disability or permanent kidney failure (end stage renal disease); or
3. You are a retired employee age 65 or over; or
4. You are the dependent spouse or domestic partner of a retired employee who is age 65 or over.

This will apply whether or not you (or your Eligible Dependent) are actually enrolled in Medicare Part A and Part B. **If you fall into one of the categories listed above (1 through 4) and you elect to not pay for Medicare Part B, benefits under this Plan will be paid as if you had elected to purchase Medicare Part B and this Plan will not pay for benefits which would have been payable under Medicare Part B.**

Change or Discontinuance of Benefits. The Employer or Plan Administrator may at any time change or discontinue the benefits provided in the Plan, but no change or discontinuance may affect in any way the amount or the terms of any benefits payable under the Plan prior to the date of such change or discontinuance.

However, any change, increase or decrease, will be subject to the Active Work requirement for a Participant and the non-confinement rule for an Eligible Dependent.

Newborns' and Mothers' Health Protection Act. The Plan may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, the Plan may not, under Federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notification of Plan Changes. The Employee Benefits Office will provide a written notice to all active employees and retirees no less than two (2) weeks prior to the scheduled BOCC meeting when proposed changes to the Employee Health Plan will be presented.

Section 16 -- Definitions

Accident. Accident and Accidental means an unforeseen or unexplained sudden occurrence by chance, without intent or volition.

Actively at Work. Active Work and Actively at Work means active full-time performance by a Participant of all customary duties of his or her occupation at the Employer or another location of business to which the Employer requires the Participant to travel. A Participant shall be deemed "Actively at Work" on each day of regular paid vacation, and on a regular nonworking day on which s/he is not disabled, provided s/he was actively at work on the last preceding working day.

Alcoholism Treatment Facility. An institution that mainly provides a program for diagnosis, evaluation and effective treatment of alcoholism. It must make charges and meet applicable licensing standards. It prepares and maintains a written treatment plan on each patient based on medical, psychological and social needs which must be supervised by a Physician. The institution must provide the following twenty-four (24) hours a day:

1. Detoxification services;
2. Infirmary level medical services required for the treatment of any Sickness or Injury manifested during the treatment period, whether or not related to the alcoholism and arrangement of Hospital level medical services, if needed;
3. Supervision by a staff of Physicians; and
4. Skilled nursing care by licensed nurses who are supervised by Registered Graduate Nurse.

Ambulatory Surgical Facility. A specialized facility which is established, equipped, operated, and staffed primarily for the purpose of performing Surgery and which fully meets one (1) of the following two (2) tests:

1. It is licensed as an Ambulatory Surgical Facility by the regulatory authority having responsibility for the licensing of such facilities under the laws of the jurisdiction in which it is located; and
2. Where licensing is not required, it meets all of the following requirements:
    a. It is operated under the supervision of a Physician who is devoting full time to supervision and permits Surgery to be performed only by a duly qualified Physician who, at the time the Surgery is performed only by a duly qualified Physician who, at the time the Surgery is performed, is privileged to perform the Surgery in at least one (1) Hospital in the area;
    b. It requires in all cases, except those requiring only local infiltration Anesthesia, that a licensed anesthesiologist administer the Anesthesia or supervise an anesthetist who is administering the Anesthesia and that the anesthesiologist or anesthetist remain present throughout the Surgery;

c. It provides at least one (1) operating room and at least one (1) post-Anesthesia recovery room;
d. It is equipped to perform diagnostic X-ray and laboratory examination or has an arrangement to obtain these services;
e. It has trained personnel and necessary equipment to handle emergency situations;
f. It has immediate access to a blood bank or blood supplies;
g. It provides the full-time services of one (1) or more Registered Graduate Nurses for patient care in the operating room and in the post-Anesthesia recovery room; and
h. It maintains an adequate medical record for each patient, the record contains an admitting diagnosis including, for all patients except those undergoing a procedure under local Anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

Ancillary Charge. A charge for services and supplies required for the care and treatment of Sickness and Injury, other than Room and Board Charges, fees for professional services, or charges for nursing care or personal items such as television, telephone, laundry, barber or beauty services, etc.

Anesthesia.

1. **Local** – The condition produced by the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body.
2. **General** – The condition produced by the administration of specific agents to render the patient completely unconscious and completely without conscious pain response.

Calendar Year. January 1st through December 31st.

Case Manager. The Case Manager functions as a liaison between the contracted employer and the Keys Physician-Hospital Alliance membership on matters related to the insured's care and charges.

Claims Administrator. The individual or entity that processes claims, precertifies benefits, provides certain financial services, provides reports and makes initial benefit determinations subject to the Plan. It does not fund or insure claim payments or bear any financial risk with regard to Plan expenses. Currently, the Claims Administrator is Acordia National, but the Plan has the discretion to change Claims Administator at any time.

COBRA continuation coverage. Any of the following: (a) Part 6 of subtitle B of Title I of ERISA; (b) section 4980B of the Internal Revenue Code of 1986, other than

subsection (f)(1) of such section insofar as it relates to pediatric vaccines; (c) Title XXII of the Public Health Services Act.

Co-payment. The portion of a Provider's Usual, Customary and Reasonable Charge that is the Participant's financial responsibility, not including any Deductibles.

Covered Medical Expenses. The Usual, Customary and Reasonable Charges incurred by or on behalf of a Participant for those covered expenses set forth in Sections 6 & 7, but only if such Usual, Customary and Reasonable Charges are incurred after the Participant commences participation in the Plan and only to the extent that the services or supplies provided to the Participant are recommended by a Physician for Medically Necessary care of any non-Occupational Sickness or Injury.

Covered Person. A Participant or an Eligible Dependent. Covered Person also means a person having Plan coverage under the Plan's COBRA continuation coverage.

Covered Service. An item, treatment, procedure, admission or medication that is Medically Necessary and appropriate for the diagnosis as set for in the Plan.

Creditable Coverage. With respect to an individual coverage under any of the following: (a) a Group Health Plan; (b) Health Insurance Coverage; (c) Part A or Part B of the Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 of such Act; (e) Chapter 55 of Title 10, Unites States Code; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under Chapter 89 of Title 5, United States Code; (i) a public health plan, as defined in regulations issued under ERISA; (j) a health benefit plan under Section 5 (d) of the Peace Corps Act (22 U.S.C. 2504(e)). The term Creditable Coverage does not include coverage consisting solely of coverage of excepted benefits, as defined in Section 706(c) of ERISA.

Custodial Care. Services and supplies that:

1. Are furnished mainly to train or assist the patient in personal hygiene and other activities of daily living, rather than to provide therapeutic treatment; and
2. Can safely and adequately be provided by persons without the technical skills of a Provider.

Such care is custodial regardless of who recommends, provides and directs it, where it is given and whether or not the patient can be or is being trained to provide self-care.

Dependent Benefits. The coverage provided under the Plan with respect to an Eligible Dependent.

Durable Medical Equipment. Equipment which is:

1. Able to withstand repeated use;
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful to a person in the absence of Sickness or Injury.

Employee. An active employee of an Employer.

Employer. The Board of County Commissioners, Clerk of the Circuit Court, Property Appraiser, Tax Collector, Supervisor of Elections and Sheriff's Department of Monroe County.

ERISA. The Employee Retirement Income Security Act (ERISA) of 1974, as presently enacted and as it may be amended from time to time, together with its related rules and regulations.

Experimental/Investigative. The use of any treatment, procedure, facility, equipment, drugs, devices or supplies not yet recognized by the Plan as acceptable medical practice as determined with the sole discretion of the Plan Administrator. This term will also apply if the services or supplies require Federal or other governmental agency approval and that approval was not granted at the time the services were received.

For purposes of the Plan, any treatment, procedure, facility, equipment, drugs, devices or supplies shall be experimental/investigate if: (a) not widely accepted throughout the Participant's geographic area by Physician Providers practicing in such geographic area as being safe, effective and appropriate for the Injury or Sickness; or (b) used for research or investigational use; or (c) conducted as part of a research protocol; or (d) not proved by statistically significant randomized clinical trials to establish increased survival or improvement in the quality of life over other conventional therapies; or (e) not approved by the Food and Drug Administration or other applicable governmental agency for general use at the time received if such approval was required to lawfully provide the drug or device; or (f) approved for a specific medical condition by the Food and Drug Administration or other applicable governmental agency but applied to another Sickness, Injury or conditions for which approval was required and not obtained at the time the drug, device, medical procedure or treatment was provided.

Extended Care Facility. A lawfully operated institution or that part of such an institution which assists patients in reaching the degree of body functioning necessary to permit self-care in essential daily living activities and:

1. Is primarily engaged in providing, under the supervision of a Physician and on a full-time Inpatient basis, care and treatment of five (5) or more persons convalescing from Injury or Sickness;
2. Provides twenty-four (24) hour-a-day professional nursing services supervised by a Registered Graduate Nurse regularly on duty within the premises;
3. Maintains a daily clinical record of each patient; and

4. Is not, except incidentally, a place for the aged, the treatment of drug or alcohol dependency, nor a place for custodial or educational care.

Family and Medical Leave Act. The Family and Medical Leave Act (FMLA) of 1993, as it may be amended from time to time, together with its related rules and regulations.

HIPAA. The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, August 21, 1996.

Home Health Care. The care and treatment of Sickness and Injury by a Home Health Care Agency.

Home Health Care Agency. An agency or organization that specializes in providing skilled nursing services and other therapeutic services and is providing Medical Care and treatment in the home. Such an agency or organization must meet all of the following requirements:

1. It is primarily engaged in providing skilled nursing services and other therapeutic services and is licensed by the Community Health Accreditation Program (CHAP) to provide such services;
2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one (1) Physician and at least one (1) Registered Graduate Nurse to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Graduate Nurse;
3. It has a full-time administrator; and
4. It maintains a complete medical record on each patient.

Hospice Care Agency. An agency or organization that offers a health care program providing a coordinated set of services rendered at home, in outpatient settings or in institutional settings for persons suffering from a condition that has a terminal prognosis. Such organization must have an interdisciplinary group of personnel which includes at least one (1) Physician and one (1) Registered Graduate Nurse, and it must maintain centralized clinical records on all patients. It must meet the standards of the National Hospice Organization (NHO) and any applicable state licensing requirements.

Hospital. An institution which:

1. Provides Medical Care and treatment of sick and Injured persons on an Inpatient basis;
2. Does so at the patient's expense;
3. Maintains facilities for surgical and medical diagnosis and treatment by or under the supervision of a staff of Physicians;
4. Provides twenty-four (24) hour-a-day nursing service by or under the supervision of a Registered Graduate Nurse;
5. Provides lab and X-ray services twenty-four (24) hours a day;

6. Operates continuously with organized facilities for Surgery; and
7. Is accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Health Care Organizations.

Injury. All injuries received by a Participant in any one (1) accident.

Inpatient. Anyone treated as a registered bed patient in a Hospital or other institutional Provider.

Intensive Care Unit. A separate and distinct part of a Hospital reserved for critically and seriously ill patients requiring highly skilled nursing care and close, frequent, if not constant, audiovisual observation and which provides for such patients the following:

1. Room and Board;
2. Nursing care by nurses whose duties are confined to the care of the patients in such unit; and
3. Specialized equipment and supplies immediately available on a standby basis segregated from the rest of the Hospital's facilities.

Keys Physician-Hospital Alliance (KPHA). The Keys Physician-Hospital Alliance is the agency selected by the Plan Administrator to provide Pre-admission Certification and Medical Case Management services.

Late Enrollee. A participant who enrolls under the Plan other than during (a) the first period in which the individual is eligible to enroll under the Plan or (b) the special enrollment period set forth in Section 3.

Medical Care. Amounts paid for: (a) the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; (b) amounts paid for transportation primarily for and essential to Medical Care referred to in subparagraph (a) of this Section; and (c) amounts paid for insurance covering Medical Care referred to in subparagraph (a) and (b) of this Section.

Medically Necessary Care (or Medical Necessity or Medically Necessary). Medically Necessary Care and treatment that is recommended or approved by a Physician; is consistent with the patient's condition, symptoms, diagnosis or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical or dental services; is not conducted for research purposes; and is the most appropriate level of service which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare. The program of Medical Care benefits provided under Title XVIII of the Social Security Act of 1965, as amended. Part A means Medicare's Hospital Plan and Part B means Medicare's Voluntary Hospital Supplemental Medical Plan.

Mental Disorder Treatment Facility. An agency or organization that provides a program for diagnosis, evaluation and effective treatment of Mental/Nervous Disorders. It is not a school, custodial, recreational or training institution. It provides infirmary-level medical services required for the treatment of any Sickness or Injury manifested during the treatment period, whether or not related to the Mental/Nervous Disorder and arranges Hospital services if needed. It has at least one (1) Psychiatrist present during the entire treatment day. It provides the services of a psychiatric social workers and a psychiatric nurse twenty-four (24) hours a day. It prepares and maintains a written treatment plan for each patient which must be supervised by a Psychiatrist. The treatment plan is based on a diagnostic assessment of the patient's medical, psychological and social needs. Such agency or organization must meet all applicable licensing requirements for facilities providing such services.

Mental/Nervous Disorders. Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Mental Health Care or Treatment. Services directed to the effective treatment of the emotional and mental well-being of the individual, including electroshock therapy administered by a Physician and Anesthesia for the same. Marital, family and financial counseling are not Covered Medical Expenses.

Morbid Obesity. A condition diagnosed by a Physician in which the patient who is over 18 years old and has completed bone growth meets one (1) or more of the following criteria:

1. The patient has a body mass index (BMI) exceeding forty (40);
2. The patient has a body mass index greater than thirty-five (35) in conjunction with severe co-morbidities that are likely to reduce life expectancy (i.e. cardiopulmonary complications, severe diabetes, severe sleep apnea, medically refractory hypertension);
3. The patient has a body weight of approximately 100 lbs. over ideal weight as provided in the Metropolitan Life and Weight table;

Body Mass Index (BMI) calculated by dividing the patient's weight in kilograms by height in meters squared. (To convert pound to kilogram, multiple pounds by 0.45. To convert inches to meters, multiply inches by 0.0254.)

Nurse Midwife/Practitioner. A person who is certified to practice as a nurse midwife in the state which the services are performed and who fulfills both of the following requirements:

1. A person licensed by a board of nursing as a Registered Graduate Nurse; and

2. A person who has completed a program approved by the state in which the person is licensed as required in subparagraph 1 of this Section for the preparation of Nurse Midwives/Practitioner.

Occupational Sickness or Injury. An Occupational Sickness or Injury is any Sickness or Injury that is related to any work that is performed for pay or profit.

Open Enrollment Period. The period elected by the Plan Administrator during which a Participating Employees and Retirees may elect to revoke a prior election to participate in the Plan's voluntary programs (Dental and/or Vision) or to add or eliminate coverage for Dependents.

Oral Surgery. Includes operations performed in or around the mouth or jaws.

Other Provider. A person or entity, other than a Hospital or Physician, which is duly licensed to render covered services.

Out-of-Pocket Limit. The Out-of-Pocket Limit is the designated limit on the amount of Covered Medical Expenses paid by a Participant during a Calendar Year **(not including Deductibles).** Specific Out-of-Pocket Limit amounts are set forth in the Schedule of Benefits. If payments by a Participant for Covered Medical Expenses during a Calendar Year equal or exceed the individual Out-of-Pocket Limit, the Plan shall then pay 100% of Covered Medical Expenses incurred during the remainder of a Calendar Year.

The Out-of-Pocket Limit shall not apply to charges in excess of a Provider's Usual, Customary and Reasonable Charge nor charges exceeding the Calendar Year limits, or any lifetime limits as set forth in the Schedule of Benefits or those expenses specifically listed as excluded in the Schedule of Benefits.

Participant. An Employee, Retired Employee, or Dependent who has satisfied the Plan's eligibility provisions and who is participating in the Plan.

Personal Benefits. Coverage provided under the Plan with respect to an Employee or Retired Employee.

Pharmacy Benefits Manager. A company under contract with managed care organizations, self-insured companies, and government programs to manage pharmacy networks, drug utilization reviews, outcome management and disease management.

Physician. The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform Surgery. It will also include any other licensed medical practitioner if he is operating within the scope of his license and performing a service for which benefits are provided under this Plan when performed by a Physician.

Physician Reviewer. The Physician Reviewer conducts those review and evaluation activities, which require a physician's expertise.

Plan. The Employee Health Plan of Monroe County.

Plan Administrator or Plan Sponsor. Board of County Commissioners, Monroe County (BOCC).

Plan Effective Date. The effective date of the Plan as amended and restated is January 1, 2007.

Precertification. A procedure to validate the Medical Necessity of a planned Hospital admission, emergency admission, surgical procedure or outpatient diagnostic service as required by the Plan. Clinical information is obtained and reviewed against established medical criteria to validate the Medical Necessity of the event and assign the length of stay for coverage purposes as appropriate. Precertification is not a guarantee of payment.

Pre-Existing Condition. An Injury or Sickness or any related condition present before the Effective Date, whether or not any medical advice, diagnosis, care or treatment was recommended or received before the Effective Date; provided, however, genetic information shall not be treated as Pre-Existing Condition in the absence of a diagnosis of the condition related to such information.

Provider. A Hospital, Physician, or Other Provider, duly licensed and performing within the scope of any applicable license.

Qualified Medical Child Support Order. A medical child support order meeting the requirements set forth in Section 609 of ERISA.

Registered Graduate Nurse. A professional nurse who has the authorization to use the title "Registered Nurse" and the abbreviation "R.N.".

Retired Employee. A former Employee retired from the Employer who is deemed qualified and eligible to receive retirement income from the Employer as a result of prior service as an Employee.

Semi-Private Room Rate. The Room and Board Charges which a Hospital or Provider applies to most beds in its semi-private rooms with two (2) or more beds.

Sickness. Physical illness, disease, alcoholism, drug abuse, or Mental/Nervous Disorder. A recurrent Sickness will be considered one (1) Sickness unless the concurrent Sicknesses are totally unrelated. For purposes of this Plan, the term "Sickness" will include Pregnancy.

Substance Abuse Treatment Facility. An institution providing a structured twenty-four (24) hour-a-day Inpatient program for diagnosis, evaluation and effective treatment of

alcoholism, and/or drug use or abuse; provides detoxification services; provides infirmary level medical services or arranges at a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Graduate Nurse; prepares and maintains written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a Physician; and meets licensing standards applicable to facilities providing such services.

Surgery. Procedures involving cutting of body tissue, debridement or permanent joining of body tissue for repair of wounds, treatment of fractured bones or dislocated joints, endoscopic procedures, and other manual procedures when used in lieu of cutting for purposes of removal, destruction or repair of body tissue.

Usual, Customary & Reasonable Charges, Fees & Expenses. The prevailing range of charges, fees and expenses charged by Providers of similar training and experience located in the same area, taking into consideration any unusual circumstances of the patient's condition that might require additional time, skill or experience to treat successfully.

Waiting Period. The period that must pass before an individual who is a potential Participant is eligible to participate in the Plan.

Board of County Commissioners --

Monroe County

Employee Health Plan

Each provision, each benefit, each page in this Plan Document for which the pages attached has been reviewed and approved by the undersigned.

This Plan Document is effective _____.

Any changes in the Plan Document shall be made by written Amendment.

Name: Board of County Commissioners – Monroe County

Approved by: _____

_____

Contact Information:

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Monroe County Board of Commissioners
1100 Simonton St., Room 2-268
Key West, Florida 33040

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Middle Keys:	(305) 743-0079 ext. 4446
Upper Keys:	(305) 852-1469 ext. 4446

Acordia National, Inc.
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Charleston, WV 25332
(800) 624-8605

Keys Physician Hospital Alliance (KPHA)
P.O. Box 9107
Key West, Florida 33041
(305) 294-4599
(800) 400-0984